

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

18885

Registrar's No.

89

Registration District No.

310

Primary Registration District No.

3058

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 80 years
years, months or days)

3. (a) PRINT FULL NAME Henry Joseph Tochtrop

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary Tochtrop
6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased June 9 1869 (1860)
(Month) (Day) (Year)

8. AGE: Years 82 Months II Days 7
If less than one day
hr. min.

9. Birthplace Wentzville, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Anton Tochtrop
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Jacoby
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Tochtrop
(b) Address RR, Wentzville, Mo.

17. (a) Burial (b) Date thereof 5-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Josephville, Mo.

18. (a) Signature of funeral director Geo. St. John
(b) Address St. Peters, Mo.

19. (a) 5/21/43 (b) Emil E. Paul
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town Josephville, R Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1943 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug 4 1943 to May 16 1943
that I last saw him alive on May 16 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 7 days
Arterio sclerosis 10 yrs.
Hypostatic pneumonia 1 day

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(a) Means of injury

23. Signature Nichols & Son (M. D. or other)
O. Fallon, Mo. Date signed 5/18/43

1340

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Elle Keithly

Licensed Embalmer No.....

844

P. O. Address.....

Wallow Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 89

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joseph Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Henry J. Tochtrop
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If alive _____ Year
7. Birth date of deceased June 9 1866
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1943 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral apoplexy Duration _____

Due to arterio sclerosis

Due to hypostatic pneumonia

Other conditions Bronchitis
(Include pregnancy within 3 months of death)

Major findings: Of operations 107

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Nicholas J. Norch (M. D. or D. O.)

Address O Fallon, Mo Date signed 6/7/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

Dr Michael J. Honi⁷
O'Fallon, IL

S-18885